TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CENTER FOR PAIN RELIEF, PA

Respondent Name
PACIFIC EMPLOYERS INSURANCE COMPANY

MFDR Tracking Number
M4-16-3679-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
August 12, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier issued incorrect allowable payment for Code J7999 KD."

Amount in Dispute: $36.29

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 6, 2016	Procedure Code J7799 — compounded drug for implantable spinal infusion pump refill	$36.29	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §134.503 sets out the pharmacy fee guideline.
4. 28 Texas Administrative Code §134.1 sets out general provisions regarding medical reimbursement.
5. Texas Labor Code §413.011 sets out general provisions regarding reimbursement policies and guidelines.
6. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, receipt acknowledged August 19, 2016. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier has not responded. Accordingly, this decision is based on the information available at the time of review.

7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 145 – Please resubmit with appropriate Fee Schedule Codes
   - 16 – Svc lacks info needed or has billing error(s)
   - KD – When drugs are infused through implanted DME
   - ORC – See Additional Information
   - P12 – Workers' Compensation State Fee Schedule Adj
   - W3 – Appeal/ Reconsideration

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Are the disputed services payable under the *Pharmacy Fee Guideline*, 28 Texas Administrative Code §134.503?
3. What is the applicable rule for determining reimbursement of the disputed services?
4. Did the requestor support that the requested reimbursement is a fair and reasonable payment?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 145 – "Please resubmit with appropriate Fee Schedule Codes."

   28 Texas Administrative Code §134.203(b)(1) requires that for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply "Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers . . . and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The item in dispute is a compounded drug to refill an implantable spinal infusion pump. The requestor provided documentation to support that the correct HCPCS code for this service on the date of service in 2016 was J7799 (where previously, in 2015, the temporary code assigned by Medicare had been Q7799). Review of the medical bill finds that the provider billed with the correct code, HCPCS code J7799. Accordingly, the Division finds that the insurance carrier's denial code 145 – "Please resubmit with appropriate Fee Schedule Codes," is not supported.

2. The Division's *Pharmacy Fee Guideline*, at 28 Texas Administrative Code §134.503(a)(2), states that "This section does not apply to parenteral drugs." While not specifically defined in the rule, "parenteral" is understood to mean a drug whose effect is systemic (non-local—i.e., topical) and whose route of administration is other than by means of the alimentary canal (that is, not oral or suppository).

   The health care provider submitted a copy of a "Customer Rx Information" sheet which states that the disputed compound is for intrathecal use (injection into the spinal canal). Intrathecal drugs fall under the "parenteral" exception in Rule §134.503(a)(2) and as such are not covered by the *Pharmacy Fee Guideline*.

   HCPCS code J7799, as billed in this dispute, is for a compounded drug intended for refill of an implanted spinal infusion pump. As such, the division concludes the disputed item is a parenteral drug and is therefore not reimbursable under the pharmacy fee guidelines regarding compounded drugs.

3. This dispute regards professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(c), which requires that:

   > To determine the MAR [Maximum Allowable Reimbursement] for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   > (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. . . .
   > (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year.

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The MAR is calculated by substituting the Division conversion factor. The applicable Division conversion factor for calendar year 2016 is $56.82.

Per the Medicare Physician Fee Schedule, procedure code J7999, service date January 6, 2016, has a Medicare payment policy status indicator of E, denoting codes excluded from the Physician Fee Schedule by regulation. CMS does not determine a price or relative value for code J7999. If payment is justified, per §134.203(f), reimbursement is provided in accordance with 28 Texas Administrative Code §134.1 regarding fair and reasonable reimbursement.

Per the Medicare Physician Fee Schedule, procedure code J7999, service date April 6, 2016, represents a compound drug (not otherwise classified) with Medicare payment policy status indicator E, denoting codes excluded from the Physician Fee Schedule by regulation. CMS does not determine a price or relative value for code J7999. If reimbursement is justified, these services are paid at a fair and reasonable rate. This code is not assigned a relative value or payment amount. If payment is justified, per §134.203(f), reimbursement is provided in accordance with 28 Texas Administrative Code §134.1 regarding fair and reasonable reimbursement.

4. The general payment provisions of 28 Texas Administrative Code §134.1 require that, in the absence of an applicable fee guideline or a negotiated contract, medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with a fair and reasonable reimbursement amount as specified in §134.1(f).

   28 Texas Administrative Code §134.1(f) requires that fair and reasonable reimbursement shall:

   (1) be consistent with the criteria of Labor Code §413.011;
   (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
   (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

   The Texas Supreme Court has summarized the statutory standards and criteria applicable to "fair and reasonable" fee determinations as requiring "methodologies that determine fair and reasonable medical fees, ensure quality medical care to injured workers, and achieve effective cost control." *Texas Workers' Compensation Commission v. Patient Advocates of Texas*, 136 *South Western Reporter Third* 656 (Texas 2004).

   Additionally, the Third Court of Appeals has held, in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 104 (Texas Appeals – Austin 2003, petition for review denied), that "each . . . reimbursement should be evaluated according to [Texas Labor Code] section 413.011(d)'s definition of 'fair and reasonable' fee guidelines as implemented by Rule 134.1 for case-by-case determinations."

   Texas Labor Code §413.011(d) requires that:

   > Fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.

   28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 . . . when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

   Review of the submitted information finds that the requestor did not discuss, demonstrate or justify how the requested reimbursement meets the requirements of §134.1(f). The requestor has failed to support that the requested payment would result in a fair and reasonable reimbursement for the services in dispute.

5. The insurance carrier allowed $2.11 for disputed HCPCS code J7999. Review of the submitted information finds insufficient documentation to support a different payment amount from that determined by the insurance carrier; therefore, additional reimbursement cannot be recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	October 25, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.